		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012914

Facility Name: Prairie City Nursing Center

Address: 825 East Main, RR 2, Box 97 (Number) Prairie City (City) 61470 (Zip Code)

County: McDonough

Telephone Number: (309) 775-3313 **Fax #** (309) 775-3311

IDPA ID Number: 37-0921343

Date of Initial License for Current Owners: 9/29/70

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Connie Morrow **Telephone Number:** (309) 772-2171

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) Trust-Mart®, PO Box 149, Bushnell, IL 61422
(Telephone) (309) 772-2171 Fax # (309) 772-3616

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 48

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	48	TOTALS	48	17,568	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,499	3,535		12,034	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,499	3,535		12,034	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.50%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	82,959	6,532	5,276	94,767		94,767		94,767			1
2	Food Purchase		57,469		57,469		57,469	(1,780)	55,689			2
3	Housekeeping	40,750	5,644	11	46,405		46,405		46,405			3
4	Laundry	20,599	5,123	485	26,207		26,207		26,207			4
5	Heat and Other Utilities			22,788	22,788		22,788		22,788			5
6	Maintenance	12,596	5,041	33,057	50,694		50,694		50,694			6
7	Other (specify):*											7
8	**TOTAL General Services**	156,904	79,809	61,617	298,330		298,330	(1,780)	296,550			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	293,333	27,852	148,389	469,574		469,574		469,574			10
10a	Therapy			2,365	2,365		2,365		2,365			10a
11	Activities	32,830	4,444	1,565	38,839		38,839	(1,307)	37,532			11
12	Social Services	17,645	10	1,390	19,045		19,045		19,045			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Pharm Consult			1,800	1,800		1,800		1,800			15
16	**TOTAL Health Care and Programs**	343,808	32,306	155,509	531,623		531,623	(1,307)	530,316			16
	C. General Administration											
17	Administrative	31,896			31,896		31,896		31,896			17
18	Directors Fees											18
19	Professional Services			5,836	5,836		5,836		5,836			19
20	Dues, Fees, Subscriptions & Promotions			6,029	6,029		6,029	(2,897)	3,132			20
21	Clerical & General Office Expenses	25,718	6,040	3,870	35,628		35,628	(2,265)	33,363			21
22	Employee Benefits & Payroll Taxes			48,021	48,021	13,915	61,936		61,936			22
23	Inservice Training & Education			621	621		621		621			23
24	Travel and Seminar			4,803	4,803		4,803		4,803			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,173	16,173	(13,915)	2,258		2,258			26
27	Other (specify):* Penalties			2,243	2,243		2,243	(2,243)				27
28	**TOTAL General Administration**	57,614	6,040	87,596	151,250		151,250	(7,405)	143,845			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	558,326	118,155	304,722	981,203		981,203	(10,492)	970,711			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie City Nursing Center #0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,497	17,497		17,497	7,458	24,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,394	6,394		6,394		6,394			32
33	Real Estate Taxes			2,189	2,189		2,189	298	2,487			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			26,080	26,080		26,080	7,756	33,836			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,841	1,841		1,841	(1,841)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,280	26,280		26,280		26,280			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			28,121	28,121		28,121	(1,841)	26,280			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	558,326	118,155	358,923	1,035,404		1,035,404	(4,577)	1,030,827			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,696)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(2,265)	21		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,458	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(84)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,307)	11		17
18	Fines and Penalties	(2,243)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,897)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,034)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,034)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Prairie City Nursing Center

ID# 0012914

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Tax Accrual	$ 298	33	1
2	Beauty & Barber Shop Expense	(1,841)	40	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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78				78
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(1,543)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie City Nursing Center # 0012914 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,780)	0	0	0	0	0	0	0	0	0	0	(1,780)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,780)	0	0	0	0	0	0	0	0	0	0	(1,780)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,897)	0	0	0	0	0	0	0	0	0	0	(2,897)	20
21	Clerical & General Office Expenses	(2,265)	0	0	0	0	0	0	0	0	0	0	(2,265)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,243)	0	0	0	0	0	0	0	0	0	0	(2,243)	27
28	**TOTAL General Administration**	(7,405)	0	0	0	0	0	0	0	0	0	0	(7,405)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,492)	0	0	0	0	0	0	0	0	0	0	(10,492)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie City Nursing Center # 0012914 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,458	0	0	0	0	0	0	0	0	0	0	7,458	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	298	0	0	0	0	0	0	0	0	0	0	298	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,756	0	0	0	0	0	0	0	0	0	0	7,756	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,841)	0	0	0	0	0	0	0	0	0	0	(1,841)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,841)	0	0	0	0	0	0	0	0	0	0	(1,841)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,577)	0	0	0	0	0	0	0	0	0	0	(4,577)	45

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	George Paul	President	Board of Directors	< 5%		2	2.00	Director Fees	$ 0	18-3	1
2	Gene Pool	Vice President	Board of Directors	< 5%		1	1.00	Director Fees	0	18-3	2
3	Larry Serven	Secretary/Treasurer	Board of Directors	- 0 -		1	1.00	Director Fees	0	18-3	3
4	John Arnold	Medical Director	Board of Directors	- 0 -		1	1.00	Director Fees	0	18-3	4
5	Dan Cortelyou	Director	Board of Directors	< 5%		1	1.00	Director Fees	0	18-3	5
6	Steve Paul	Director	Board of Directors	- 0 -		1	1.00	Director Fees	0	18-3	6
7											7
8											8
9	(NO DIRECTOR FEES PAID)										9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Farmers & Merchants Bank		X	Operating Expense	None	04/22/99	38,000		10/22/99	10.8000		6
7	Farmers & Merchants Bank		X	Operating Expense	None	07/22/99	100,000	100,000	01/31/01	11.5000	6,394	7
8												8
9	TOTAL Facility Related						$ 138,000	$ 100,000			$ 6,394	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 138,000	$ 100,000			$ 6,394	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	3,284	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2,189	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,095)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	3,582	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	2,487	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	2,011	8
	1996	1,991	9
	1997	2,119	10
	1998	2,189	11
	1999	2,786	12

2000 accrual is 6 months worth of 2000 tax payable in 2001 plus all of 1999 tax bill received in August 2000.

Real estate tax actually paid during this fiscal year was 1998 tax (billed in 1999); both 1998 and 1999 bills were received late.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 211,164 B. General Construction Type: Exterior Brick Frame Steel/Brick Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building Lot	211,164	1970	$ 6,512	1
2					2
3	TOTALS	211,164		$ 6,512	3

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1970		$ 326,774	$ 9,902	33	$ 9,902	$	$ 293,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Storage Building			1974	483		10			483	9
10	Septic Tank			1973	2,755		15			2,755	10
11	Air Conditioner			1976	5,657		15			5,657	11
12	Insulation			1978	15,149	606	25	606		13,113	12
13	Planter			1979	600		10			600	13
14	Laundry & Improvements			1980	2,222		15			2,222	14
15	Smoke Detectors			1983	2,321		10			2,321	15
16	Office Carpet			1983	478		15			478	16
17	Waste Tank			1982	1,630		20	82	82	1,476	17
18	Roof			1985	27,391	1,370	25	1,096	(274)	16,615	18
19	Patio Carpet			1986	1,847	96	15	123	27	1,753	19
20	Generator Shed			1986	838	44	20	42	(2)	598	20
21	Light Fixtures			1988	535	17	10		(17)	535	21
22	Fire Door			1988	2,674	85	20	134	49	1,742	22
23	Water Heater			1989	717		10			717	23
24	Fence			1990	150	5	25	6	1	66	24
25	Doors			1990	1,048	33	15	70	37	723	25
26	Wall Paper			1990	1,700	54	10	114	60	1,700	26
27	Carpet			1990	2,730	87	10	205	118	2,730	27
28	Wall Paper			1990	1,870	59	10	140	81	1,870	28
29	Lighting			1990	3,180	101	10	292	191	3,180	29
30	Shed			1990	9,139	290	20	457	167	4,608	30
31	Storage Shed Improvements			1991	1,275	40	20	64	24	640	31
32	Storm Windows			1991	814	26	15	54	28	540	32
33	Insulation			1991	2,489	79	25	100	21	1,000	33
34	Lights			1991	400	13	10	40	27	400	34
35										3,220	35
36	TOTAL (lines 4 thru 35)				$ 416,866	$ 12,907		$ 13,527	$ 620	$ 365,659	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel Bathroom			1993	2,421	62	39	62		453	9
10	Remodel Closets			1995	2,715	70	33	82	12	451	10
11	Plumbing Replacement			1996	15,075	548	27	548		2,316	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 20,211	$ 680		$ 692	$ 12	$ 3,220	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 129,939	$ 3,609	$ 10,585	$ 6,976		$ 88,729	37
38	Current Year Purchases	2,104	301	151	(150)		301	38
39	Fully Depreciated Assets	121,494					121,494	39
40								40
41	TOTALS	$ 253,537	$ 3,910	$ 10,736	$ 6,826		$ 210,524	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	None			$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 697,126	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 17,497	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 24,955	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 7,458	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 579,403	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	None	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	None	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NO RENTAL COSTS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Prairie City Nursing Center **#** 0012914 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 56,322	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		127,706	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		8,893	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 192,921	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		6,512	13
14	Buildings, at Historical Cost		435,075	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		255,541	16
17	Accumulated Depreciation (book methods)		(605,142)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 91,986	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 284,907	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 21,094	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)		3,875	31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,582	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 28,551	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		135,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 135,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 163,551	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 121,356	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 284,907	48

***(See instructions.)**

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 237,611	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 237,611	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(116,255)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (116,255)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 121,356	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 976,326	1
2	Discounts and Allowances for all Levels	(67,501)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 908,825	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,811	12
13	Barber and Beauty Care	1,327	13
14	Non-Patient Meals	1,667	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	1,683	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,488	23
	D. Non-Operating Revenue		
24	Contributions	1,793	24
25	Interest and Other Investment Income***	732	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,525	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Program Income	1,307	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,307	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 919,145	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	298,330	31
32	Health Care	531,623	32
33	General Administration	151,250	33
	B. Capital Expense		
34	Ownership	26,080	34
	C. Ancillary Expense		
35	Special Cost Centers	1,841	35
36	Provider Participation Fee	26,280	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,035,404	40
41	**Income before Income Taxes (line 30 minus line 40)****	(116,259)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (116,259)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **See pg. 25**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,272	2,352	$ 30,384	$ 12.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,035	4,153	54,543	13.13	3
4	Licensed Practical Nurses	6,152	6,406	71,301	11.13	4
5	Nurse Aides & Orderlies	18,702	19,228	137,105	7.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,325	4,429	32,830	7.41	9
10	Activity Assistants					10
11	Social Service Workers	1,965	2,043	17,645	8.64	11
12	Dietician					12
13	Food Service Supervisor	1,966	2,014	18,029	8.95	13
14	Head Cook	1,671	1,775	10,556	5.95	14
15	Cook Helpers/Assistants	10,056	10,289	54,374	5.28	15
16	Dishwashers					16
17	Maintenance Workers	1,644	1,736	12,596	7.26	17
18	Housekeepers	7,582	7,763	40,750	5.25	18
19	Laundry	3,791	3,881	20,599	5.31	19
20	Administrator	2,040	2,040	31,896	15.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,807	3,018	25,718	8.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	69,008	71,127	$ 558,326 *	$ 7.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,297	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	89	1,800	15-3	39
40	Physical Therapy Consultant	15	2,365	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	1,390	11-3	44
45	Social Service Consultant	9	1,390	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	$ 11,242		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	34	$ 1,283	10-3	50
51	Licensed Practical Nurses	1,138	33,646	10-3	51
52	Nurse Aides	3,478	45,734	10-3	52
53	TOTAL (lines 50 - 52)	4,650	$ 80,663		53

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sheila Johnson	Administrator	0	$ 9,615
Larry Serven	Administrator	0	2,885
F. Kaye Burris	Administrator	0	19,396
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,896

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Prairieland/Trust-Mart	Payroll/Tax Prep	$ 5,155
Virginia McKinley	Accounting	681
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,836

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,915
Unemployment Compensation Insurance	5,045
FICA Taxes	42,712
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	264
TOTAL (agree to Schedule V, line 22, col.8)	$ 61,936

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	555
Health Care Worker Background Check	228
(Indicate # of checks performed 19)	
IHCA	1,944
PAC	230
NHA Licenses	175
Other Promo & Fees	2,897
Less: Public Relations Expense	(2,897)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,132

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,094
(No amounts over $250)	
Seminar Expense	1,709
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,803

**See instructions.

Facility Name & ID Number Prairie City Nursing Center # 0012914 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie City Nursing Center # 0012914 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $1944**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,131** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **26,280**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,667**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A - Facility does not own a vehicle**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Prairie City Nursing Center # 0012914 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

Pg. 21, Sch XIX-G: Seminar Expense

Name	Job Title	Dates Attended	Location	Title	Sponsor	Cost
Debbie Sloan	Activity Director	6/21/99 - 6/22/99	Springfield	IHCA	IHCA	80.00
Amy Fugate	Care Plan Coordinator	7/2/1999	Peoria	Care Plan Assessment MDS 2.0	MAPS	200.00
Linda McGrew	RN/DON	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Christie Butler	Administrator	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Brenda Green	Social Services	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Debbie Sloan	Activity Director	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Marjorie Riden	Food Service Support	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Sharon Taflinger	RN	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Nancy Taylor	LPN	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Amy Fugate	Care Plan Coordinator	9/15/99 - 9/19/99	Springfield	IHCA	IHCA	56.75
Marjorie Riden	Dietary Manager	1/18/2000	Macomb	Current Topics in Nutrition	University of Illinois	30.00
Wronda White	Dietary	1/28/2000	Bushnell	Sanitation Course	Carl Sandberg College	85.50
Lynn Tucker	Dietary	1/28/2000	Bushnell	Sanitation Course	Carl Sandberg College	85.50
Kay Burris	Administrator	2/1/2000	Springfield	Facility Responses to Deficiency	IHCA	70.00
Alissa Thorne	DON	2/1/2000	Springfield	Facility Responses to Deficiency	IHCA	70.00
Kay Burris	Administrator	3/22/2000	Peoria	Wound Care	Enloes	94.24
Debbie Sloan	Activity Director	4/4/2000	Canton	Activity Class	Spoon River Activity Association	25.00
Nancy Sinnett	Activity Director	4/4/2000	Canton	Activity Class	Spoon River Activity Association	25.00
Alissa Thorne	DON	4/25/2000	Peoria	Care Plan Update	MAPS	25.00
Brenda Green	Social Services Director	4/25/2000	Peoria	Care Plan Update	MAPS	25.00
Kay Burris	Administrator	4/11/00 - 4/12/00	Springfield	INHAA Convention	INHAA/IHCA	75.00
Kay Burris	Administrator	5/4/2000	Peoria	Workman's Comp	NHRMA	35.00
Patricia Moore	Care Plan Coordinator	6/15/2000	Peoria	MDS Training	MAPS	250.00
Patricia Moore	Care Plan Coordinator	6/30/2000	Springfield	MDS Training	IHCA	80.00
						$1,709.24

Pg. 3, Sch V: Explanation of Reclassification of Expenses

Reclassify workers' compensation insurance premiums included in insurance account:

Employee Benefits & Payroll Taxes	$ 13,915
Insurance-Prop. Liab./Malpractice	(13,915)
	$0

Pg. 19, Sch XVII: Reconciliation of Income Statement with Federal Income Tax Return

Income before taxes	$ (116,259)
Penalties	2,243
Taxable income per 1120	$ (114,016)